July 10, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-03-0875-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified anesthesiologist. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 53 year-old female who sustained a work related injury to her back on ___. The patient reported that while at work she sustained a repetitive motion injury to her back when she had to continuously reach behind her while performing her work duties. The diagnoses for this patient have included degenerative disc disease lumbar spine, lumbar spinal stenosis and post operative wound infection. The patient underwent a back fusion in February 2002. The patient has also been treated with passive and active physical therapy, multiple surgeries, trigger point injections, epidural steroid injections, chiropractic care, psychological intervention and medication management.

Requested Services

Chronic Pain Management Program times 30 days.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 53 year-old female who sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the patient was evaluated and initially underwent a surgical intervention in 1991. The ___ physician

reviewer further noted that the patient continued to complain of back pain and eventually underwent spinal fusion in 2002. The ___ physician reviewer indicated that the patient has undergone numerous interventions for pain control including medical therapy, passive and active physical therapy, chiropractic care, trigger point injections, epidural steroid injection therapy and psychological intervention. The ___ physician reviewer explained that despite these treatments, the patient continued to complain of low back pain. The ___ physician reviewer noted that medical treatment for this patient has included Neurontin, Paxil, and Oxycontin. The ___ physician reviewer explained that the patient's chronic pain condition warrants a multidisciplinary approach that can only be offered in a structured chronic pain management program. The ___ physician reviewer also explained that the patient has undergone a psychological evaluation that indicated the patient has an atypical depression directly related to continued pain from the work related injury. The ___ physician reviewer further explained that a multidisciplinary approach to this patient's chronic pain should significantly improve her coping skills and self-regulation ability to improve her overall level of function. Therefore, the ___ physician consultant concluded that the requested chronic pain management program times 30 days is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

___

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 10th day of July 2003.